

**BOARD OPINION**  
**RELATING TO OFFICE-BASED SURGERY**

**LEGAL AUTHORITY**

Pursuant to KRS 311.602, the following Board opinion is issued to assist Board licensees in determining what actions would constitute unacceptable conduct under the provisions of KRS 311.595. The Board has decided to publish this opinion because it addresses issues of significant public and medical interest.

This opinion is not a statute or administrative regulation and it does not have the force of law.

**ACCEPTABLE AND PREVAILING MEDICAL PRACTICES OF OFFICE-BASED SURGERY**

**I. STATEMENT OF INTENT AND GOALS**

This opinion is issued to promote patient safety in the non-hospital setting during procedures that require the administration of conscious sedation, local, or general anesthesia, or minor or major conduction blockade. Moreover, this opinion is published to provide practitioners performing office-based surgery, (including cryosurgery and laser surgery), that requires anesthesia (including tumescent anesthesia), analgesia or sedation a summary of what, in the Board's opinion, constitutes the acceptable and prevailing medical practices and principles regarding qualification of practitioners and staff, equipment, facilities and policies and procedures for patient assessment and monitoring. *Minor procedures in which unsupplemented local anesthesia is used in quantities equal to or less than the manufacturer's recommended dose, adjusted for weight, are excluded from this opinion. Nonetheless, it is the acceptable and prevailing medical practice that any practice performing office-based surgery regardless of anesthesia have the necessary equipment, protocol, and personnel to handle emergencies resulting from the procedure and/or anesthesia.*

It is the Board's opinion that the following principles constitute the standards of acceptable and prevailing medical practice relating to the delivery of office-based surgery. In making this determination, the Board has considered the relevant statutes (which are cited where appropriate), practice standards relating to physicians' conduct and interactions with other health care professionals and basic practice standards.

**II. DEFINITIONS**

For purposes of this opinion, the following terms are defined as follows:

- A. *“Advanced cardiac life support trained”* means that a licensee has successfully completed and requalified periodically an advanced cardiac life support course offered by a recognized accrediting organization appropriate to the licensee’s field of practice. For example, for those licensees treating adult patients, training in advanced cardiac life support (ACLS) is appropriate; for those treating children, training in pediatric advanced life support (PALS) or advanced pediatric life support (APLS) is appropriate.
- B. *“Anesthesiologist”* means a physician who has successfully completed a residency program in anesthesiology approved by the Accreditation Council of Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA), or who is currently a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before 1982.
- C. *“Anesthetizing location”* means any location in an office where anesthetic agents are administered to a patient.
- D. *“Board”* means the Kentucky Board of Medical Licensure.
- E. *Certified registered nurse anesthetist” (CRNA)* means a registered nurse who successfully completed an advanced, organized formal educational program in nurse anesthesia accredited by the national certifying organization of such specialty which is recognized by the Kentucky Board of Nursing; and is certified by a board approved national certifying organization, and who demonstrates advanced knowledge and skill in the delivery of anesthesia services. The Certified Registered Nurse Anesthetist should practice in accordance with approved written guidelines developed under the supervision of a licensed physician or dentist or approved by the medical staff within the facility where the practice privileges have been granted.
- F. *“Complications”* means an untoward event occurring at any time within 48 hours of surgery, special procedure or the administration of anesthesia in an office setting including, but not limited to, any of the following: paralysis, nerve injury, malignant hyperthermia, seizures, myocardial infarction, renal failure, significant cardiac events, respiratory arrest, aspiration of gastric contents, cerebral vascular accident, transfusion reaction, pneumothorax, allergic reaction to anesthesia, unintended hospitalization for more than 24 hours, or death.
- G. *“Credentialed”* means that a practitioner or physician has been granted and continues to maintain the privilege by a facility licensed in the jurisdiction in which it is located to provide specified services, such as surgery or the administration or supervision of the administration of one or more types of anesthetic agents or procedures, or can show adequate documentation of training experience in specified services such as surgery that is performed more often in an office or outpatient setting.

- H. *“Deep sedation/analgesia”* means the administration of a drug or drugs which produces depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- I. *“General anesthesia”* means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
- J. *“Health care personnel”* means any office staff member who is licensed or certified by a recognized professional or health care organization such as but not limited to a professional registered nurse, licensed practical nurse, physician assistant or certified medical assistant.
- K. *“Hospital”* means a hospital licensed by the state in which it is situated.
- L. *“Local anesthesia”* means the administration of an agent which produces a transient and reversible loss of sensation in a circumscribed portion of the body.
- M. *“Major surgery”* means surgery which requires moderate sedation, deep sedation, general anesthesia, or major conduction blockade for patient comfort.
- N. *“Major conduction blockade”* means the injection of local anesthesia to stop or prevent a painful sensation in a region of the body. Major conduction blocks include, but are not limited to, axillary, interscalene, and supraclavicular block of the brachial plexus; spinal (subarachnoid), epidural and caudal blocks.
- O. *“Minimal sedation” (anxiolysis)* means the administration of a drug or drugs which produces a state of consciousness that allows the patient to tolerate unpleasant medical procedures while responding normally to verbal commands. Cardiovascular or respiratory function should remain unaffected and defensive airway reflexes should remain intact.
- P. *“Minor surgery”* means surgery which can be safely and comfortably performed on a patient who has received local or topical anesthesia, without more than minimal pre-operative medication or minimal intraoperative sedation and where the likelihood of complications requiring hospitalization is remote.
- Q. *“Minor conduction block”* means the injection of local anesthesia to stop or prevent a painful sensation in a circumscribed area of the body (that is, infiltration or local nerve block), or the block of a nerve by direct pressure and refrigeration.

Minor conduction blocks include, but are not limited to, intercostal, retrobulbar, paravertebral, peribulbar, pudendal, sciatic nerve and ankle blocks.

- R. *“Moderate sedation/analgesia”* means the administration of a drug or drugs which produces depression of consciousness during which patients respond purposely to verbal commands, either alone or accompanied by a light tactile stimulation. Reflex withdrawal from painful stimulation is NOT considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- S. *“Monitoring”* means continuous visual observation of a patient and regular observation of the patient as deemed appropriate by the level of sedation or recovery using instruments to measure, display and record physiologic values such as heart rate, blood pressure, respiration and oxygen saturation.
- T. *“Office”* means a location at which medical or surgical services are rendered and which is not subject to a jurisdiction and licensing requirements.
- U. *“Office-Based Surgery”* means the performance of any surgical or other invasive procedure requiring anesthesia, analgesia, or sedation, including cryosurgery and laser surgery, which results in patient stay of less than 24 consecutive hours and is performed by a practitioner in a location other than a hospital or a diagnostic treatment center, including free-standing ambulatory surgery centers.
- V. *“Operating room”* means that location in the office dedicated to the performance of surgery or special procedures.
- W. *“Physical status classification”* means a description of a patient used in determining if an office surgery or procedure is appropriate. The American Society of Anesthesiologists enumerates the following classifications: I – Normal, healthy patient; II – A patient with mild systemic disease; III – A patient with severe systemic disease limiting activity but not incapacitating; IV – A patient with incapacitating systemic disease that is a constant threat to life; and V – Moribund patients not expected to live 24 hours with or without operation.
- X. *“Physician”* means an individual holding an M.D. or D.O. degree licensed pursuant to the Kentucky Medical and Osteopathic Practices Act.
- Y. *“Practitioner”* means a physician.
- Z. *“Recovery area”* means a room or limited access area of an office dedicated to providing medical services to patients recovering from surgery or anesthesia.
- AA. *“Special procedure”* means patient care which requires entering the body with instruments in a potentially painful manner, or which requires the patient to be immobile, for a diagnostic or therapeutic procedure requiring anesthesia services; for example, diagnostic or therapeutic endoscopy, invasive radiologic

procedures, pediatric magnetic resonance imaging; manipulation under anesthesia or endoscopic examination with the use of general anesthetic.

- BB. *“Surgery”* means any operative or manual procedures, including the use of lasers as used under the direction of a physician in certain cases, performed for the purpose of preserving health, diagnosing or treating disease, repairing injury, correcting deformity or defects, prolonging life or reliving suffering, or any elective procedure for aesthetic or cosmetic purposes. This includes, but is not limited to: incision or curettage of tissue or an organ; suture or other repair of tissue or an organ; extraction of tissue from the uterus; insertion of natural or artificial implants; closed or open fracture reduction; or an endoscopic examination with use of local or general anesthetic.
- CC. *“Topical Anesthesia”* means an anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

### **III. OFFICE ADMINISTRATION**

In the Board’s opinion, it is the acceptable and prevailing medical practice that office-based surgical practices adopt written policies and procedures which are subject to periodic review and updating.

#### **A. Policies and Procedures**

Written policies and procedures can assist office-based practices in providing safe and quality surgical care, assure consistent personnel performance, and promote an awareness and understanding of the inherent rights of patients. The following are important aspects of an office-based practice that should benefit from simple policy and procedure statements.

##### **1. Emergency Care and Transfer Plan**

It is the acceptable and prevailing medical practice to have a plan in place which provides for emergency medical care as well as the safe and timely transfer of patients to a nearby hospital should hospitalization be necessary and which includes the following:

- a. Age appropriate emergency supplies, equipment and medication in accordance with the scope of surgical and anesthesia services provided at the practitioner’s office.
- b. In an office where anesthesia services are provided to infants and children, required emergency equipment appropriately sized for a pediatric population, and personnel appropriately trained to handle pediatric emergencies (APLS or PALS certified).

- c. A practitioner who is qualified in resuscitation techniques and emergency care should be present and available until all patients having more than local anesthesia or minor conductive block anesthesia have been discharged from the office (Advanced adult or pediatric life support certified).
- d. In the event of untoward anesthetic, medical or surgical complications or emergencies, personnel should be familiar with the procedures and plan to be followed, and able to take the necessary actions. All office personnel should be familiar with a documented plan for the timely and safe transfer of patients to a nearby hospital. This plan should include arrangements for emergency medical services, if necessary, or when appropriate escort of the patient to the hospital by an appropriate practitioner. If advanced cardiac life support is instituted, the plan should include immediate contact with emergency medical services.

## 2. Medical Record Maintenance and Security

It is the acceptable and prevailing medical practice to have a procedure for initiating and maintaining a health record for every patient evaluated or treated and that each record include a procedure code or suitable narrative description of the procedure and sufficient information to identify the patient, support the diagnosis, justify the treatment and document the outcome and required follow-up care. For procedures requiring patient consent, it is the acceptable and prevailing medical practice to obtain and maintain documented informed written consent. If analgesia/sedation, minor or major conduction blockade or general anesthesia are provided, it is the acceptable and prevailing medical practice to include documentation of the type of anesthesia used, drugs (type and dose) and fluids administered, the record of monitoring of vital signs, level of consciousness during the procedure, patient weight, estimated blood loss, duration of the procedure, and any complications related to the procedure or anesthesia. In addition, it is the acceptable and prevailing medical practice to maintain procedures that assure patient confidentiality and security of all patient data and information.

## 3. Infection Control Policy

It is the acceptable and prevailing medical practice to comply with state and federal regulations regarding infection control. For this reason, for all surgical procedures, the level of sterilization should meet current OSHA requirements; there should be a procedure and schedule for cleaning, disinfecting and sterilizing equipment and patient care items; personnel should be trained in infection control practices, implementation of universal precautions, and disposal of hazardous waste products; and protective clothing and equipment should be readily available.

#### 4. Performance Improvement

It is the acceptable and prevailing medical practice to periodically review (minimum of every six months) the current practice activities and quality of care provided to patients, including peer review by members not affiliated with the same practice. Level I facilities may be exempt from these reviews.

Performance improvement (PI) can be established by:

- a. Establishment of a PI program by the practice; or
- b. Cooperative agreement with a hospital-based performance or quality improvement program; or
- c. Cooperative agreement with another practice to jointly conduct PI activities; or
- d. A cooperative agreement with a peer review organization, a managed care organization, specialty society, or other.

#### 5. Reporting of Adverse Incidents

In the Board's opinion, anesthetic or surgical mishaps requiring resuscitation, emergency transfer, or death should be reported to the Board within three business days.

#### 6. Federal and State Laws and Regulations

It is the acceptable and prevailing medical practice to identify and comply with federal and state laws and regulations that affect the practice.

The following are some of the key requirements upon which office-based practices should focus:

- a. Non-Discrimination (see Civil Rights statutes and the Americans with Disabilities Act)
- b. Personal Safety (see Occupational Safety and Health Administration information)
- c. Controlled Substance Safeguards
- d. Laboratory Operations and Performance (CLIA)
- e. Personnel Licensure Scope of Practice and Limitations

#### 7. Patients' Bill of Rights

It is the acceptable and prevailing medical practice to ensure that office personnel recognize the basic rights of patients and understand the importance of maintaining patients' rights. A patients' rights documents should be readily available upon request.

### IV. CREDENTIALING

#### A. Surgical Facility

It is the acceptable and prevailing medical practice that practices performing office-based surgery or procedures that require the administration of moderate or deep sedation, or general anesthesia (Level II and III facilities as defined below) be accredited by an accreditation agency, including the American Association of Ambulatory Surgical Facilities (AAAASF), Accreditation Association for Ambulatory Health Care (AAAHC) or the Joint Commission of Accreditation of HealthCare Organizations (JCAHO), or any other agency approved by the Board within the first year of operation. The accrediting agency should submit a yearly summary report for each facility to the Board. Any licensee performing Level II or Level III office surgery should register with the Board. Such registration should include each address at which Level II or Level III office surgery is performed and identification of the accreditation agency that accredits each location (when applicable). Rule of Thumb: The capacity of the patient at all times to retain his/her life-protective reflexes and to respond to verbal command (i.e., the depth of sedation or anesthesia) – rather than the specific procedure performed – lies at the core of differentiating Level II from Level III surgery.

##### 1. Level I Office Surgery

Level I office surgery includes:

- a. Minor procedures performed under topical or local anesthesia (including digital block) not involving drug-induced alteration of consciousness other than minimal preoperative anti-anxiety medications.
- b. Tumescant liposuction: total lidocaine dosage should not exceed 55 mg/kg in a Level I facility.
- c. Preoperative medications are not required or used other than minimal preoperative perioperative oral or intramuscular anti-anxiety producing drugs; anesthesia is local, topical, or none. No drug-induced alteration of consciousness other than minimal anxiolysis of the patient is permitted in Level I Office Surgery.
- d. Chances of Complications requiring hospitalization are remote.

##### 2. Level II Office Surgery:

Level II office surgery includes the following:

- a. Any procedure which requires the administration of minimal or moderate intravenous, intramuscular, or rectal sedation/analgesia, thus making post-operative monitoring necessary.



- b. Level II office surgery shall be limited to procedures where there is only a moderate risk of surgical and/or anesthetic complications and the likelihood of hospitalization as a result of these complications is unlikely. Level II office surgery includes local or peripheral nerve block, minor conduction blockade, and Bier block.

3. Level III Office Surgery:

Level III office surgery includes the following:

- a. Level III office surgery is any procedure which requires, or reasonably should require, the use of deep sedation/analgesia, general anesthesia, or major conduction blockade, and/or in which the known complications of the proposed surgical procedure may be serious or life-threatening.
- b. Tumescant liposuction: supranatant fat removal should not exceed 4000cc.

B. Practitioner:

- 1. It is the acceptable and prevailing medical practice that a practitioner only perform surgical procedures and anesthesia services which are commensurate with the practitioner's level of training and experience.

Criteria to be considered to demonstrate competence include:

- a. State licensure
- b. Procedure-specific education, training, experience and successful evaluation appropriate for the patient population being treated (i.e., pediatrics)
- c. For physician practitioners, board certification, board eligibility or completion of a training program in a field of specialization recognized by the ACGME for expertise and proficiency in that field. Board certification is understood as American Board of Medical Specialists (ABMS) or equivalent board certification as determined by the Board for non-physician practitioners, certification that is appropriate and applicable for the practitioner.
- d. Professional misconduct and malpractice history.
- e. Participation in peer and quality review

- f. Participation in continuing education consistent with the statutory requirements and requirements of the practitioner's professional organization
  - g. Malpractice insurance coverage adequate for the specialty
  - h. Procedure-specific competence (and competence in the use of new procedures/technology), which should encompass education, training, experience and evaluation, and which may include the following:
    - (1) Adherence to professional society standards;
    - (2) Hospital and/or ambulatory surgical privileges for the scope of services performed in the office based setting;
    - (3) Credentials approved by a nationally recognized accrediting/credentialing organization; and
    - (4) Didactic course complimented by hands-on, observed experience; training is to be followed by a specified number of cases supervised by a practitioner already competent in the respective procedure, in accordance with professional society standards and guidelines may be acceptable if approved by the Kentucky Board of Medical Licensure.
2. Unlicensed personnel may not be assigned duties or responsibilities that require professional licensure. Duties assigned to unlicensed personnel should be in accordance with their training, education and experience and under the direct supervision of a practitioner.

## **V. STANDARDS FOR OFFICE PROCEDURES**

### **A. Level I Office Procedures**

#### **1. Training**

It is the acceptable and prevailing medical practice that the surgeon pursue continuing medical education in proper drug dosages, management of toxicity or hypersensitivity to local anesthetic and other drugs. It is recommended that the surgeon obtain Advanced Cardiac Life Support certification.

#### **2. Equipment and supplies**

It is the acceptable and prevailing medical practice that oxygen, positive pressure ventilation device, epinephrine, atropine, antihistamine, and corticosteroids be available if any anesthesia is used.

### 3. Assistance of Other Personnel

It is the acceptable and prevailing medical practice that no other assistance be required, unless dictated by the surgical procedure.

### 4. Accreditation

No accreditation is necessary for Level I office surgery.

## **B. Level II Office Procedures**

### 1. Training

It is the acceptable and prevailing medical practice that the surgeon have staff privileges to perform the same procedure in a hospital as that being performed in the outpatient setting or be able to document satisfactory completion of training such as board certification or board eligibility by a board approved by the American Board of Medical Specialties, formal training, or experience. It is the acceptable and prevailing medical practice that the surgeon and one assistant be certified in Basic Life Support and the surgeon or at least one assistant certified in Advanced Cardiac Life Support or have a qualified anesthetic provider practicing within the scope of the provider's license to manage the anesthetic.

### 2. Equipment and Supplies

It is the acceptable and prevailing medical practice that emergency resuscitative equipment and a reliable source of oxygen as outlined in the appendix be current and readily available; that monitoring equipment include a continuous suction device, pulse oximeter, and noninvasive blood pressure cuff; that electrocardiographic monitoring be available for patients with a history of cardiac disease; and that age appropriate sized monitors and resuscitative equipment be available for pediatric patients.

### 3. Assistance of Other Personnel

It is the acceptable and prevailing medical practice that anesthesia be administered only by a licensed, qualified and competent practitioner. Registered professional nurses (RNs) who administer analgesic or sedative drugs as part of a medical, procedure (*including but not limited to Certified Registered Nurse Anesthetists (CRNAs)*) should have training and experience appropriate to the level of anesthesia administered and function in accordance with their scope of practice. Registered professional nurses (RNs) should have documented competence to administer conscious sedation and to assist in any support or resuscitation measures as required. It is the acceptable and prevailing medical practice that the individual

administering conscious sedation and/or monitoring the patient not assist the surgeon in performing the surgical procedure. It is the acceptable and prevailing medical practice that supervision of the sedation/analgesia component of the medical procedure be provided by a *physician who is physically present*, who is qualified by *law, regulation, or hospital appointment to perform* and supervise the administration of the sedation/analgesia or minor conduction blockade and who has accepted responsibility for supervision.

The *physician* providing supervision should:

- a. Assure that an appropriate preanesthetic examination and evaluation is performed proximate to the procedure;
- b. Prescribe the anesthesia;
- c. Assure that qualified practitioners participate;
- d. Remain physically present during the entire perioperative period and immediately available for diagnosis, treatment, and *management* of anesthesia-related complications or emergencies; and
- e. Assure the provision of indicated post-anesthesia care.

A registered nurse who is certified in Basic Cardiac Life Support (BCLS) should monitor the patient postoperatively and have the capability of administering medications as required for analgesia, nausea/vomiting, or other indications. Monitoring in the recovery area should include pulse oximetry and non-invasive blood pressure measurement. The patient should be assessed periodically for level of consciousness, pain relief, or any untoward complication. Each patient should meet discharge criteria as established by the practice, prior to leaving the facility.

#### 4. Transfer and Emergency Protocols

It is the acceptable and prevailing medical practice that the surgeon have a transfer protocol in effect with a hospital within reasonable proximity.

#### 5. Facility Accreditation

It is the acceptable and prevailing medical practice that the surgeon obtain and maintain Level II accreditation of the office setting by one of the approved agencies.

### **C. Level III Office Procedures**

#### 1. Training

- a. It is the acceptable and prevailing medical practice that the surgeon have documented training to perform the particular surgical

procedure(s) and in the event he/she is supervising the administration of anesthesia by a Certified Registered Nurse Anesthetist, he/she have sufficient knowledge of the anesthetic technique specified by him/her for the procedure to assure compliance with the Kentucky Medical and Osteopathic Practice Act. The CRNA shall practice pursuant to approved written guidelines developed with the supervising licensed physician or dentist or by the medical staff within the facility where practice privileges have been granted. Rule 81-110 requires, among other things, that the surgeon be competent to supervise the specified anesthetic technique. If the surgeon does not possess the requisite knowledge of anesthesia, the anesthesia should be administered by an Anesthesiologist or by a Certified Registered Nurse Anesthetist supervised by an Anesthesiologist.

- b. It is the acceptable and prevailing medical practice that the surgeon and at least one assistant maintain certification in Basic Cardiac Life Support and that the surgeon or at least one assistant maintain certification in Advanced Cardiac Life Support, and/or if appropriate, Pediatric Advanced Life Support (PALS) (or other profession specific equivalent training).
- c. It is the acceptable and prevailing medical practice that recovery from general anesthesia or deep sedation be monitored by an ACLS (PALS or PLS when appropriate) trained practitioner.

## 2. Equipment and Supplies

- a. It is the acceptable and prevailing medical practice that emergency resuscitation equipment, suction, a reliable source of oxygen and at least 12 ampules of dantrolene sodium be readily available. [See Appendix]
- b. It is the acceptable and prevailing medical practice that monitoring include:
  - (1) Blood pressure (apparatus and stethoscope)
  - (2) Pulse oximetry
  - (3) Continuous EKG
  - (4) Capnography
  - (5) Temperature monitoring for procedures lasting longer than thirty minutes

It is the acceptable and prevailing medical practice that the facility, in terms of general preparation, equipment and supplies, be comparable to a free standing ambulatory surgical center, have provisions for proper record keeping, and the ability to recover patients after anesthesia.

## 3. Assistance of Other Personnel:

It is the acceptable and prevailing medical practice that an anesthesiologist, other qualified physician, or a Certified Registered Nurse Anesthetist, directed by a physician, administer the general, deep sedation or major conduction regional anesthesia. If the anesthetic is administered by a Certified Registered Nurse Anesthetist, the anesthetic component of the procedure should be supervised by a *physician, who is physically present*, and who is qualified to supervise the administration of the anesthetic technique specified by him/her and who has accepted responsibility for such supervision. It is the acceptable and prevailing medical practice that the anesthesia provider not function in any other capacity during the procedure and that recovery from general anesthesia, deep sedation, or major conduction blockade be monitored by a practitioner with Advanced Cardiac Life Support or Pediatric Advanced Life Support (or other profession specific equivalent training). Recovery from anesthesia should be evaluated by a qualified practitioner for proper anesthesia recovery using criteria that is appropriate for the level of anesthesia.

#### 4. Inspection and Accreditation

It is the acceptable and prevailing medical practice that the surgeon obtain and maintain accreditation of the office setting by AAAASF, AAAHC and JCAHO. All expenses related to accreditation or inspection should be paid by the surgeon.

## VI. PATIENT ADMISSION AND DISCHARGE

### A. Patient Selection

It is the acceptable and prevailing medical practice that the physician evaluate the condition of the patient and the potential risks associated with the proposed treatment plan. The physician is responsible for determining that the patient has an adequate support system to provide for necessary follow-up care. Patients with pre-existing medical problems or other conditions, who are at undue risk for complications, should be referred to an appropriate specialist for pre-operative consultation.

It is the acceptable and prevailing medical practice that patients, who are considered high risk or are a physical classification status III or greater and require a general anesthetic for the surgical procedure, have the surgery performed in a hospital setting. Patients with a physical status classification of III or greater may be acceptable candidates for moderate sedation/analgesia.

ASA Class III patients should be specifically addressed in the operating manual of the surgery center. They may be acceptable candidates if deemed so by a

physician qualified to assess the specific disability and its impact on anesthesia and surgical risks.

Acceptable candidates for a deep sedation, general anesthesia, or major conduction blockade are patients with a physical status classification of I or II, no airway abnormality, and possess an unremarkable anesthetic history.

## **B. Informed Consent**

It is the acceptable and prevailing medical practice that the risks, benefits, and potential complications of both the surgery and anesthetic be discussed with the patient and/or, if applicable, the patient's legal guardian prior to the surgical procedure. Written documentation of informed consent should be included in the medical record.

## **C. Preoperative Assessment**

It is the acceptable and prevailing medical practice that a medical history and physical examination be performed, and appropriate laboratory studies obtained within 30 days of the planned surgical procedure, by a practitioner qualified to assess the impact of co-existing disease processes on surgery and anesthesia. In addition, it is the acceptable and prevailing medical practice that a preanesthetic examination and evaluation should be conducted immediately prior to surgery by the physician, who will be administering or supervising the anesthesia. *If a certified registered nurse anesthetist will be administering the anesthesia, she/he should collaborate in such examination or evaluation.* The information and data obtained during the course of these evaluations should be documented in the medical record.

## **D. Discharge Evaluation**

It is the acceptable and prevailing medical practice that the physician who administered or supervised the anesthesia evaluate the patient immediately upon completion of the surgery and anesthesia and prior to transferring care of the patient to qualified nursing personnel in the recovery area. A physician should remain immediately available until the patient meets discharge criteria.

Criteria for discharge for all patients who have received anesthesia include the following:

1. Confirmation of stable vital signs
2. Stable oxygen saturation levels
3. Return to pre-procedure mental status
4. Adequate pain control
5. Minimal bleeding nausea and vomiting
6. Resolving neural blockade, resolution of the neuraxial blockade

7. Discharged in the company of a competent adult

**E. Patient Instructions**

It is the acceptable and prevailing medical practice that the patient be given verbal instruction understandable to the patient or guardian and written post-operative instructions and emergency contact numbers.

The instructions should include:

1. The procedure performed;
2. Information about potential complications;
3. Telephone numbers to be used by the patient to discuss complications or should questions arise;
4. Instructions for medications prescribed and pain management;
5. Information regarding the follow-up visit date, time and location; and
6. Designated treatment facility in the event of emergency.

Published as Board Opinion on June 16, 2011



## **Appendix I**

### **Emergency and Resuscitation Equipment**

#### **A. Level I Facility**

- I. Reliable oxygen supply
- II. Airway equipment; appropriate sized oral airways, endotracheal tubes, laryngoscopes, and masks
- III. Positive pressure ventilation device (bag/mask)
- IV. Suction
- V. Drugs:
  - a. Epinephrine
  - b. Atropine
  - c. Antihistamines
  - d. Hydrocortisone
- VI. Monitors:
  - a. If the anesthetic performed possesses any possibility of a complication that may compromise the patient's hemodynamic status or level of conscious, appropriate monitors include non-invasive blood pressure and pulse oximetry.
  - b. If topical anesthesia is applied or minimal anxiolysis administered, no monitoring required.

#### **B. Level II and III Facilities**

- I. Reliable oxygen source with back up tank
- II. Airway equipment; appropriate sized oral airways, endotracheal tubes, laryngoscopes, and masks
- III. Positive pressure ventilation device
- IV. Equipment
  - a. Defibrillator
  - b. Double tourniquets if the practice performs Bier blocks
  - c. Non-invasive blood pressure apparatus
  - d. Pulse oximeter
  - e. Capnography
  - f. Electrocardiographic monitor
  - g. Temperature monitoring system for procedures lasting more than 30 minutes
  - h. Oxygen analyzer
- V. Suction Apparatus
- VI. Drugs:
  - a. Epinephrine
  - b. Atropine
  - c. Antihistamines
  - d. Hydrocortisone

- e. Ephedrine
- f. Vasopressors (norepinephrine, isoproterenol, dopamine)
- g. Calcium Chloride or gluconate
- h. Glucose
- i. Naloxone
- j. Romazicon
- k. Antiemetics
- l. Sodium bicarbonate
- m. Lidocaine
- n. Adenosine
- o. Magnesium Sulfate
- p. Digoxin
- q. Furosemide
- r. Potassium Chloride
- s. Heparin sodium
- t. Aspirin
- u. Amiodarone
- v. Verapamil
- w. Procainamide
- x. Nitroglycerin
- y. Esmolol
- z. Labetolol
- aa. A minimum of 12 ampules of dantrolene sodium – if general anesthesia is administered

## **Appendix II**

### **Equipment for the Administration of General Anesthesia or Deep Sedation**

- A. Equipment as described in Appendix I, A-F
- B. Equipment required whenever the nature of the procedure requires the presence of an anesthesia circuit:
  - 1. an accepted method of identifying and preventing the interchange ability of anesthetic gases, whenever gases are used
  - 2. a respirometer (volumeter) measuring exhaled tidal volume
  - 3. Oxygen failure-protection devices ("fail-safe" system) which has the capacity to alert the practitioner when a reduction in oxygen pressure and, at lower levels of oxygen pressure, to discontinue other gases when the pressure of the supply of oxygen is reduced.
  - 4. alarm systems for high, low (subatmospheric), and minimum ventilatory pressures (disconnect) in the breathing circuit for each patient under general anesthesia
  - 5. Gas evacuation system
- C. When inhalational anesthetics are administered there should be:
  - 1. a vaporizer exclusion ("interlock") system when more than one vaporizer is present
  - 2. Pressure compensated anesthesia vaporizers which are placed in the circuit upstream from the oxygen flush valve
  - 3. Flow meters and controllers, which can accurately measure concentration of the oxygen relative to the anesthetic agent and prevent oxygen mixtures of less than 21% from being administered
  - 4. a reliable system to scavenging waste anesthetic gases
  - 5. equipment for the management of the difficult airway and to treat malignant hyperthermia

## **Appendix III**

### **Sample Patient Bill of Rights**

1. The patient has the right to high quality health care delivered in a safe and efficient manner.
2. The patient has a right to dignity and respect.
3. The patient has a right to privacy, confidentiality, and consideration of any legitimate concerns.
4. The patient has a right to know his or her diagnosis, treatment options and prognosis.
5. The risks, benefits, and possible complications of each treatment or procedure need to be addressed.
6. The patient has the right to know the qualifications of individuals who will be participating in their care.
7. The patient has the right to refuse treatment and be advised of the consequences of this decision.
8. The patient has a right to inspect and obtain a copy of his or her medical records.
9. Charges to the patient to obtain the medical record should not be excessive.
10. The patient has a right to inspect and obtain information regarding the billing services.
11. The patient has a right to request information regarding alternative appropriate care.
12. The patient has a right to know the expectations of his or her behavior and the consequences of not complying with these expectations.

## **Appendix IV**

### **Major Accrediting Agencies**

American Association for Accreditation of Ambulatory Surgical Facilities, Inc.  
(AAAASF)  
1202 Allanson Road  
Mundelein, IL 60060  
(847)949-6058

Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)  
9933 Lawler Avenue  
Skokie, IL 60077-3702  
(847)676-9610

Joint Commission on Accreditation of HealthCare Organizations (JCAHO)  
One Renaissance Boulevard  
Oak Brook Terrace, IL 60181  
(630)916-5600

Clinical Laboratory Improvement Amendments of 1988 (CLIA)  
Administrator, Health Care Financing Administration  
Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201  
(202)690-6726

## **Appendix V**

### **Useful Administrative Information**

#### **A. Occupational Safety and Health Administration (OSHA)**

OSHA is a division of the US Department of Labor and is responsible for the enforcement of the health and safety guidelines set forth in the OSHA Act of 1970. Practices are subject to OSHA Hazard Communications Standard of 1987 and the Blood Borne Pathogen Standard 29 CFR 1910 1030. Both standards have very specific requirements and require written policy manuals and formal training regarding the standards. Other applicable OSHA standards include Access to Employee Exposure and Medical Records, and Personal Protective Equipment.

#### **B. Americans with Disabilities Act**

Copies may be obtained by calling the Equal Employment Opportunity Commission at 1-800-669-4000 or [www.eeoc.gov](http://www.eeoc.gov)

#### **C. National Fire Protection Association-NFPA Life Safety Code**

National Fire Protection Association  
One Batterymarch Park  
P.O. Box 9101  
Quincy, MA 02269-9101  
(617)770-4543

#### **D. Codes of Ethical Business and Professional Behavior**

American College of Surgeons  
55 East Erie Street  
Chicago, IL 60611-2797  
(312)202-5000

#### **E. American Society of Anesthesiologists**

520 North Northwest Highway  
Park Ridge, IL 60068-2573  
(847)828-5586  
[www.asa.hq.org](http://www.asa.hq.org)

#### **F. American Medical Association**

515 North State Street  
Chicago, IL 60610  
1-800-634-6922 or 1-800-621-8335

#### **G. The American Association of Nurse Anesthetists**

222 South Prospect Avenue  
Park Ridge, IL 60068-4001  
(847)698-7050  
[www.aana.com](http://www.aana.com)